

To be completed by participants at the end of their first session.

Living Well with Chronic Conditions **Participant Information**

Thank you for completing this form. We do not need your name!
This information will help us evaluate and expand the Living Well program in Oregon.

1. What COUNTY do you live in? _____

2. Gender ___ Male ___ Female

3. What is your age? _____ years

4. What chronic condition(s) do you have? (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cancer/Survivor | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Lung Disease/COPD | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Other – please list _____ | | |
| <input type="checkbox"/> Here to support family or friend | | |

5. What is your race/ethnicity? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> White |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Other – please list _____ |

6. Do you have any kind health insurance (including HMOs, Medicare, or Oregon Health Plan)? ___ Yes ___ No

7. Do you now use tobacco (cigars, cigarettes, or smokeless tobacco, etc.)?

___ Every day ___ Some days ___ Not at all

8. How did you hear about this workshop? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Doctor, nurse, or other health care provider's office | |
| <input type="checkbox"/> Community- or Faith-based Organization/Senior Center | |
| <input type="checkbox"/> Work | <input type="checkbox"/> Newspaper/Radio/TV |
| <input type="checkbox"/> Friend/Family | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Other: _____ | |

Questions? Call us at 1-888-576-7414.